

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 2984  
601

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
<b>1. PLACE OF DEATH</b> a. COUNTY _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>Selling</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST LOUIS MISSOURI</b>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Harrisburg</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Barnes Hospital,</b>				d. STREET ADDRESS (If rural, give location) <b>148 Dayton</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>JESSIE</b>		a. (First) <b>JESSIE</b>		b. (Middle) <b>MCINTOSH</b>		c. (Last) <b>MCINTOSH</b>	
<b>5. SEX</b> <b>F</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>WIDOWED</b>		<b>8. DATE OF BIRTH</b> <b>12-23-1898</b>	
<b>9a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>9b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Scotland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13a. FATHER'S NAME</b> <b>James Carmichael</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Joseph</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Frank McIntosh</b>	
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (a) <b>Shock during operation</b>  <b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) <b>Hypertension</b>  DUE TO (c) <b>Cancer of larynx</b>  <b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.			
<b>19a. DATE OF OPERATION</b> <b>1-19-1949</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>Cancer left half of larynx &amp; slightly right side.</b>			
<b>21a. ACCIDENT, SUICIDE, HOMICIDE</b> (Specify) _____				<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____				<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from Dec 18, 1948, to Jan. 19, 1949, that I last saw the deceased alive on Dec 18, 1948, and that death occurred at 6 p. m., from the causes and on the date stated above.</b>							
<b>23a. SIGNATURE</b> (Degree or title) <b>Wm. H. Ryan M.D.</b>				<b>23b. ADDRESS</b> <b>Barnes Hospital</b>		<b>23c. DATE SIGNED</b> <b>1-19-1949</b>	
<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>24b. DATE</b> <b>JAN 20 1949</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Sunset Town</b>		<b>24d. LOCATION (City, town, or county) (State)</b> <b>Harrisburg Illinois</b>	
<b>DATE REC'D BY LOCAL REG.</b> <b>JAN 21 1949</b>		<b>REGISTRAR'S SIGNATURE</b> <b>J. B. Lasater</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Rowland Mort. Service</b>		<b>ADDRESS</b> <b>4109 Manchester</b>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 4343

P. O. Address St Louis Mo

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.